

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011471  
STATE FILE NUMBER  
2 3048

XC-17 477 247  
SL 19045  
FILED APR 10 1959

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>915 N. GRAND, ST. LOUIS, MO.</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VET. ADM. HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>3929 KENNERLY AVE.</b>	
Length of stay in lb <b>44 days</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>AUGUST</b> Last <b>VARWIG</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/6/88</b>
9. AGE (In years last birthday) <b>71</b>		10. FUNDING YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CHAUFFEUR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DAIRY COMPANY</b>	
11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>HENRY VARWIG</b>		13b. MOTHER'S MAIDEN NAME <b>AMELIA SICKMAN</b>	
14. NAME OF HUSBAND OR WIFE -----			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input checked="" type="checkbox"/> unknown) (If yes, give name dates of service) <b>WW-1</b>		16. SOCIAL SECURITY NO. <b>490-01-3222</b>	
17. INFORMANT <b>VA HOSP. RECORDS, ST. LOUIS, MO.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTASES TO BONS AND MEDULLA OF CA OF LUNG</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 MONTHS</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>CARCINOMA OF R U LOBE</b>		UNKNOWN	
DUE TO (c) <b>163 X</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION <b>VAH, ST. LOUIS, MO.</b>		COUNTY STATE	
21. attended the deceased from <b>2/7/59</b> to <b>3/23/59</b> and last saw him alive on <b>3/23/59</b> Death occurred at <b>5:40 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>JEWELL A. Osterholm</b> (Degree or title) <b>M.D.</b>		22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>	
22c. DATE SIGNED <b>3/23/59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>3/26/59</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bothany Cometary</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri.</b>	
24. FUNERAL DIRECTOR <b>CALVIN F. FEUTZ, 4828 NAT'L BRIDGE BLVD</b>		25. DATE RECD. BY LOCAL REG. <b>MAR 26 '59</b>	
26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed .....

*John A. Mullen*

Licensed Embalmer No. *4186*...

P. O. Address *St. Louis, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.